Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

HANNA J ABU NASSAR MD
P O BOX 741865
DALLAS TX 75374

Carrier's Austin Representative Box
Box Number 19

Respondent Name

LUMBERMENS UNDERWRITING ALLIANCE

MFDR Date Received
January 18, 2012

MFDR Tracking Number
M4-12-1662-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "DESIGNATED DOCTOR EXAM; CARRIER IS REQUIRED TO PAY DESIGNATED DOCTOR EXAMS; THE CURRENT RULES ALLOW REIMBURSEMENT; AN ORIGINAL BILL AND A RECONSIDERATION WERE SUBMITTED, THE CURRENT RULES ALLOW REIMBURSEMENT."

Amount in Dispute: $1,053.44

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Requestor has filed a Request for Dispute Resolution identifying this as a fee dispute. There is, however, a pending and unresolved compensability dispute concerning the extent of the injury. Accordingly, this request must be held in abeyance in accordance with 38 TAC §§133.305(b)…Subject to the Motion to Abate and final resolution of any liability, compensability and extent of injury disputes, Carrier asserts it has properly denied and paid the services in question."

Response Submitted by: Flahive, Ogden & Latson, P. O. Drawer 201320, Austin, TX 78720

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 19, 2011	99456-RE-W6 99456-RE-W7 99456-RE-W8 99456-RE-W9 95851	$500.00 $250.00 $125.00 $125.00 $53.44	$0.00 $500.00 $0.00 $0.00 $0.00
TOTAL		$1,053.44	$500.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Texas Administrative Code §134.204 sets out the fee guidelines for the reimbursement of workers' compensation specific codes, services and programs provided on or after March 1, 2008.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated November 2, 2011
   - 080 – Denied per carrier
   - 186 – Claim is denied
   - 218 – Based on entitlement to benefits
   - R38 – Included in another billed procedure
   - 97 – Charge Included in another Charge or Service

   Explanation of benefits dated December 6, 2011
   - 080 – Denied per carrier
   - 193 – Original payment decision maintained
   - B15 – Procedure/Service is not paid separately
   - 168 – No additional allowance recommended
   - 219 – Based on Extent of Injury

Issues

1. The carrier has addressed issue of compensability for the claim. How does this affect a Designated Doctor (DD) examination requested by the injured employee?
2. Has the Designated Doctor (DD) examination been reimbursed appropriately per 28 Texas Administrative Code §134.204?
3. Is CPT code 95851 included in the MMI/IR examination?
4. Is the requestor entitled to reimbursement for the disputed services under 28 Texas Administrative Code §134.204?

Findings

1. On the EOBs dated November 2, 2011 and December 6, 2011, the respondent denied reimbursement based upon "080 – Denied per carrier'; "186 – Claim is Denied" ; "218 – Based on entitlement to benefits"; and "219 – Based on Extent of Injury."

   Texas Labor Code §408.0041 states in part (a)(1)(2)

   (a) At the request of an insurance carrier or an employee, or on the commissioner's own order, the commissioner may order a medical examination to resolve any question about:

   (4) Whether the injured employee's disability is a direct result of the work-related injury

   Texas Labor Code §408.0041 states in part (h)(1)

   (h) The insurance carrier shall pay for:

   (1) An examination required under Subsection (a) or (f).

   The completion of a Designated Doctor examination requested by the injured employee is payable per the above statue and is not subject to the status of the claim.

2. Per 28 Texas Administrative Code §134.204 reimbursement is as follows:

   CPT code 99456-RE-W6: The specific wording on the DWC032 states, "Determine if the injury is a direct result of the accident." Per Texas Administrative Code §134.204(i)(1)(C), CPT code 99456-RE-W6 is a Return to Work (RTW) and/or Evaluation of Medical Care (EMC) examination to determine the extent of the employees compensable injury. This is not a service that was requested to be performed per the DWC032, therefore, reimbursement is not recommended.

   CPT code 99456-RE-W7: The specific wording on the DWC032 states, "Determine if the injury is a direct result of the accident." Per 28 Texas Administrative Code §134.204(i)(1)(D) and (k), the Maximum Allowable Reimbursement (MAR) for the billing and reimbursement of the Return to Work

(RTW) and/or Evaluation of Medical Care (EMC) examination to determine whether the injured employees disability is a direct result of the work-related injury is $500.00.

CPT code 99456-RE-W8: The specific wording on the DWC032 states, "Determine if the injury is a direct result of the accident." Per 28 Texas Administrative Code §134.204(i)(1)(E), CPT code 99456-RE-W8 is a Return to Work (RTW) and/or Evaluation of Medical Care (EMC) examination to determine the ability of the employee to return to work. This is not a service that was requested to be performed per the DWC032, therefore, reimbursement is not recommended.

CPT code 99456-RE-W9: The specific wording on the DWC032 states, "Determine if the injury is a direct result of the accident." Per 28 Texas Administrative Code §134.204(i)(1)(F),CPT code 99456-RE-W9 is a Return to Work (RTW) and/or Evaluation of Medical Care (EMC) examination an examination to determine other similar issues. This is not a service that was requested to be performed per the DWC032, therefore, reimbursement is not recommended.

3. The provider also billed the amount of $51.28 for 2 units of Range of Motion (ROM) testing for the MMI/IR examination. There was no reimbursement for the CPT code by the respondent. However, two medical fee guidelines rules address testing that is included in the overall MMI/IR examination reimbursement.

   28 Texas Administrative Code §134.204 (j)(1)(E):

   (j) Maximum Medical Improvement and/or Impairment Rating (MMI/IR) examinations shall be billed and reimbursed as follows:

   (1) The total MAR for an MMI/IR examination shall be equal to the MMI evaluation reimbursement plus the reimbursement for the body area(s) evaluated for the assignment of an IR. The MMI/IR examination shall include:

   (E) tests used to assign the IR, as outlined in the AMA Guides to the Evaluation of Permanent Impairment (AMA Guides), as stated in the Act and Division rules in Chapter 130 of this title (relating to Impairment and Supplemental Income Benefits).

   Per the rules above, Range of Motion (ROM) is included in the reimbursement for the MMI/IR exam and is not separately payable. No additional amount for CPT code 95851 can be recommended.

4. The respondent has previously reimbursed the amount of $0.00 for the disputed services. Therefore, the requestor is due a recommended reimbursement in the amount of $500.00.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $500.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $500.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

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Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	July 25, 2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.